STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Battlefield Park Healthcare Center	250 Flank Road Petersburg, VA 23805

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40026 Based on observation, interview, clinical record review and facility documentation the facility staff failed to ensure a Resident's right to a dignified existence for 4 Residents (# 5, # 33, # 58 and #114) in a survey sample of 42 Residents. The findings included: 1. For Resident #5 the facility staff failed to ensure the facial hair on her chin was removed. Resident #5's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/27/24 coded Resident #5 as having a BIMS (Brief Interview of Mental Status) score of 5/15 indicating severe cognitive impairment. Resident #5 was coded as requiring partial or moderate assistance of 1 staff with bathing, dressing and grooming. Resident #5 had diagnoses that included but were not limited to type 2 Diabetes, COPD (Chronic Obstructive Pulmonary Disease), chronic kidney disease stage 4, hypertension, congestive heart failure, depression, cellulitis of left lower limb, and atrial fibrillation. On 9/17/24 at approximately 12:00 p.m. Resident #5 was observed sitting in bed she was dressed in a hospital gown, her hair unkempt and gray facial hair approximately 1 inch long on her chin. Resident #5 was questioned about the facial hair, and she stated that she tries to pull it out, but she can't. When asked if the CNA's shave her on bath days she stated that they did not help her with her bath, she stated that most times she just washes up. A review of the clinical record revealed that the POC (Point of Care - CNA documentation record) coded Resident #5 as, 06 - Independent Resident performs activity without assistance. On 9/17/24 at approximately 2:00 p.m. an interview was conducted with CNA B who stated that Resident #5 needed help with most things including bathing. When asked if she should be left to do her own shower or bath, she stated that it would not be safe to do so and even if it was safe she wouldn't be able to complete the task properly due to her cognitive and physical status. When asked if facial hair should be removed during bath or shower days, she stated that it should. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/17/24 at approximately 3:00 p.m. the DON escorted surveyor down the hall and observed Resident #5 the DON was then asked if facial hair should be removed from female Residents and she stated that it should. When asked what impact that could have on a female Resident, she stated it could make them feel bad about themselves as a woman. She stated that it is, a dignity issue. On 9/19/24 during the end of day meeting the Administrator was made aware of the concern and no further information was provided. 2. For Resident # 33 the facility staff failed to ensure the Resident was dressed in clean clothing. Resident #33 was admitted to the facility on [DATE] with diagnoses that included but were not limited to history of stroke with hemiplegia, dementia, and diabetes. Resident #33's most recent MDS with an ARD of 6/29/24 scored the Resident as having a BIMS score of 9/15 indicating severe cognitive impairment. On 9/17//24 at approximately 11:45 a.m. Resident #33 was observed sitting in the doorway of his room in his wheelchair. Resident #33 was dressed in dark pants and a white t-shirt. The pants were stained in the front and had crumbs in his lap the shirt had brownish yellow stains that appeared dry. Resident #33 was unable or unwilling to answer questions when asked by the surveyor. On 9/17/24 at 2:30 p.m. Resident #33 was still wearing the same t-shirt and pants with the stains on them. On 9/17/24 at 3:00 p.m. an interview was held with CNA C who stated that she was not assigned to Resident #33, but she agreed that his clothing was dirty and needed to be changed. She stated would get him cleaned up as his clothing did appear soiled and his face and hands could use washing. On 9/19/24 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided. 3. For Resident # 58 the facility staff failed to cover the foley urine drainage bag with a dignity cover. Resident #58 was admitted to the facility on [DATE] with diagnoses that included but were not limited to coronary artery disease, congestive heart failure, peripheral vascular disease, diabetes, chronic kidney disease and dementia. Resident #58's most recent MDS with an ARD of 7/25/24 scored the Resident as having a BIMS score of 5/15 indicating severe cognitive impairment. On 9/17//24 at approximately 11:25 a.m. Resident #58 was observed sitting in a wheelchair dressed appropriately however she had a foley urinary drainage bag hooked to the wheelchair that was not covered with a dignity bag. On 9/17/24 at 3:00 p.m. Resident #58 was observed again without a dignity bag covering her foley drainage bag. On 9/17/24 at approximately 4:15 p.m. an interview was conducted with CNA B who stated that foley drainage bags should be covered with a dignity bag. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On the morning of 9/18/24 Resident # 58 was not in the building, and interview was conducted with the DON who stated that all Residents who have foley catheters should have them covered with a dignity bag to protect their privacy and preserve their dignity. The DON stated that CNA's are supposed to ensure the foley bag is covered. On 9/19/24 the Administrator was made aware of the findings and no further information was provided. 34894 4. For Resident # 114, the facility failed to ensure personal clothing was worn on 9/18/2024. Resident # 114 was dressed in a hospital gown. Resident # 114 was admitted to the facility in August 2024 with diagnoses that included but were not limited to:Schizophrenia, history of traumatic brain injury, Anxiety Disorder, Glaucoma, legal blindness and Chronic Embolism and Thrombosis. The most recent MDS (Minimum Data Set) was an Admission Assessment with an ARD (Assessment Reference Date) of 8/21/2024. The MDS coded Resident # 114 as having a BIMS (Brief Interview of Mental Status) score of 3/15 indicating severe cognitive impairment. Resident # 114was coded as requiring assistance of 1 staff with bathing, dressing and grooming. On 9/18/2024 at 1:15 p.m., Resident # 114 was observed wearing a hospital gown while sitting in a wheelchair at the bedside. The gown was short and exposed Resident # 114's knees. When the surveyor spoke to Resident # 114, he was observed attempting to cover himself by placing his hands on his lap and pulling the gown toward his knees. On 9/18/2024 at 3:08 p.m., Resident # 114 was observed sitting in the wheelchair in the doorway to the room and still dressed in a hospital gown. On 9/18/2024 at 4:00 p.m., Resident # 114 was observed sitting in the wheelchair in the doorway to the room and still dressed in a hospital gown. On 9/18/2024 at 4:30 p.m., Resident # 114 was observed lying in bed with a hospital gown on. Review of the Clinical Record revealed no documentation of Resident # 114 refusing to wear personal clothing on 9/18/2024 or any other day. Review of the Care Plan revealed Resident # 114 needed assistance with Activities of Daily living to include maximum assistance with dressing. There was no problem/concern listed indicating a history of refusing care or assistance. On 9/19/2024 at 9:00 a.m., a Certified Nursing Assistant (CNA)-E was observed providing morning care to Resident # 114. The Certified Nursing Assistant (CNA-E) dressed the resident in Dark blue shorts and a blue T-shirt. An interview was conducted with Certified Nursing Assistant-E who stated the expectation was for residents to be dressed in their own personal clothing every day after their baths or morning care. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/19/2024 at 9:30 a.m., an interview was conducted with the Director of Nursing who stated the expectation was for all residents to be dressed in their personal clothing unless they refuse. The Director of Nursing stated there was no documentation that Resident # 114 refused to be dressed in personal clothing on 9/18/2024. On 9/19/2024 at 12:15 p.m., an interview was conducted with the the Administrator who stated the expectation was for residents to be dressed in their own clothing. The Administrator stated residents should wear regular clothing just like everyone else. She stated that was a dignity issue. On 9/19/2024 at 2:45 p.m., the Administrator, Assistant Administrator, Regional Consultant and Director of Nursing were informed of the findings. No further information was provided.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 49455 Based on resident interview, staff interview, and review of facility documents, the facility's staff failed to arrange regular unit council meetings for residents and/or family representatives. The findings included: An interview was conducted with the facility's Activities Assistant (AA) on 9/17/24 at approximately 1:30 PM. The AA stated that the Activities Director (AD) had been out on leave since January of this year, and she had been working alone in the department since then. The AA also stated that she was not officially trained to set up unit council meetings, but she has been doing the best she could. The AA stated that the Executive Director (ED) helped her with the most recent unit council meeting this month. The AA further stated that she did miss ensuring meetings were held some months this year. An interview was conducted with the ED on 9/18/24 at approximately 11:45 AM. The ED stated that the AD went out on leave in January and then resigned last month. ED also stated that the position is posted and that she has been working with the AA to assure unit council meetings are held monthly. The ED acknowledged that meetings had not been consistent. The ED was able to provide unit council minutes for 7/16/24 and 9/16/24. The ED provided a unit council sign in sheet dated 5/21/24 without any minutes, no meeting was held in June of 2024, a sign in sheet and minutes were provided for 7/16/24, no meeting was held in August of 2024, and sign in sheet and minutes were provided for 9/16/24. The facility's policy titled Resident's Rights, undated reads, Residents have a right to form or participate in a resident group to discuss issues and concerns about the facilities policies and operations such as resident council. On 9/19/24 at approximately 5:00 PM, the above findings were shared with the Executive Director (Administrator), Director of Nursing, Assistant Director of Nursing, Regional Minimum Data Set Coordinator, and Regional Corporate Consultant. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided.

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident has the right to receive notices in a format and a language he or she understands. 49455 Based on observation, resident interview, staff interview, and review of facility documents, the facility's staff failed to ensure residents were aware of their right to contact the Ombudsman to advocate for them and of their right to file a complaint with the state certification agency. The findings included: During the unit council meeting held in the facility on 9/18/24 at approximately 2:30 PM, zero of the six residents that attended was aware of what or who their Ombudsman was or how to contact them. Also, zero of the six residents in attendance were aware that they could make a complaint with the state agency and where they could find the information to do so. An interview was conducted with the facility's Activities Assistant (AA) on 9/18/24 at approximately 4:00 PM. When asked, Has it been your practice to assure residents know how to contact the Ombudsman and/or file a complaint with the state agency if necessary? The AA said, no. When asked, Have you ever observed the previous AD assure residents were aware of how to find this information? The AA said, no. An interview was conducted with the Admissions Coordinator (AC) on 9/18/24 at approximately 7:45 PM over the phone. The AC stated it was a collaborative effort of all facility staff and leadership to inform residents on where to find information on how to contact the Ombudsman and/or state agency. The residents who were in attendance of the unit council meeting on 9/18/24 were all shown where this information was located. The residents were thankful to know where they could find recourses to help them when they have concerns. This information was observed in the facility's lobby to the right as you walk in. It was observed in a high traffic area as it is right at the entrance to the facility. The facility's policy titled Resident's Rights, undated reads, Residents have a right to make complaints. On 9/19/24 at approximately 5:00 PM, the above findings were shared with the Executive Director (Administrator), Director of Nursing, Assistant Director of Nursing, Regional Minimum Data Set Coordinator, and Regional Corporate Consultant. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided.

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. 49455 Based on resident interview, staff interview, and review of facility documents, the facility's staff failed to ensure residents packages were received unopened. The findings included: During the unit council meeting held in the facility on 9/18/24 at approximately 2:30 PM, three of the six residents that attended complained that their packages are always opened when received. These residents said that their mail is received unopened, but packages were always opened. The residents were frustrated and said it was an invasion of their privacy. An interview was conducted with the facility's Executive Director (ED) on 9/18/24 at approximately 4:15 PM. The ED stated that residents should received their mail and packages unopened and that she was unaware that resident's packages have been received open. The facility's policy titled Resident's Rights, undated reads, Residents have a right to have privacy in sending and receiving mail. On 9/19/24 at approximately 5:00 PM, the above findings were shared with the Executive Director (Administrator), Director of Nursing, Assistant Director of Nursing, Regional Minimum Data Set Coordinator, and Regional Corporate Consultant. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40026 Based on observation, interview, and facility documentation the facility staff failed to ensure a clean, comfortable homelike environment for the Residents on the 100's hall and any Residents that receive food from the kitchen. The findings included: For the Residents on the e100's hall and those receiving food from the kitchen the following observations were made: 9/17/24 - 9/19/24 - during the 3 days of survey flies and gnats were noted in the conference room by all surveyors, dead bugs were noted in light fixtures throughout the building. 9/17/24 at 11:55 a.m. - floors in the hallway have stains near room [ROOM NUMBER] and 111. 9/17/24 at 12:05 p.m. - room [ROOM NUMBER] A area above bed has been repaired and spackled but not painted. 9/17/24 at 12:10 p.m. - room [ROOM NUMBER] B IV pole and floor have brownish substance dried on them appears to be tube feeding. 9/17/24 at 1:30 p.m. - Shower room was cluttered with 4 shower chairs a shower stretcher a weight scale, 2 vital signs machines, an IV pole. There were dirty wet towels on the sink/vanity as well as draped across the sharps container that was mounted on the wall. A nebulizer machine that was unlabeled and undated was sitting on the vanity/sink area. There were several missing tiles on the base board and floor and the clean linen cart had no towels, wash cloths, or hospital gowns on it only a few pillowcases. On 9/18/24 at 9:00 a.m. the shower room was noted to be in the same condition with the clutter and dirty linens as well as the nebulizer and lack of linens. A review of the pest control service book revealed that between April 2024 and August 2024 the pest control company made monthly recommendations to the facility to aid in keeping pests at bay the recommendations included cleaning drains, replacing and repairing door sweeps and drywall, cleaning the kitchen shelves of food debris, and sealing up areas where mice were entering. These recommendations were made monthly and appear to continue to be an issue and have gone unaddressed. On 9/18/24 at 10:30 a.m. am interview was conducted with CNA B who stated that the shower room was not used for storage it was an actively used for showers daily. When asked what items should be on the linen cart in the shower room, she stated that there should be wash cloths, towels and hospital gowns as well as sheets on the cart. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/18/24 at 12:40 p.m. an interview was conducted with the DON. She was asked if the shower room appeared cluttered, she stated that it did. When asked if the nebulizer machine should be left in there, she stated that since it is not labeled she had no idea of who it belonged to but if it is not in use, it should be in the dirty utility room so that it may be sanitized. When asked if the linen cart should be filled, she stated that it should. When asked about the missing tiles she stated she was unaware they needed repair. On 9/19/24 during the end of day meeting the Administrator was made aware of the findings and no further information was provided.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34306 Based on review of the resident record, staff interviews and a review of facility documents, the facility staff failed to notify the Office of the State Long-Term Care Ombudsman in writing of a hospital discharges for 1 of 42 residents (Resident #67), in the survey. The findings included: Resident #67 was originally admitted to the facility 2/4/2022 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included quadriplegia, stage 4 pressure ulcers of the left groin and right gluteal fold and an obstructive uropathy. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/6/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #67's cognitive abilities for daily decision making were intact. A Nurse Practitioner's note dated 11/8/23 read that Resident #67 was observed unresponsive by a Certified Nursing Assistant (CNA). The note further read that the resident was observed lying in bed with a blank stare but he would track with his eyes when his name was called and the resident's temperature was 101.4 (forehead). The resident was transferred to a local hospital on 11/8/23 and admitted for seizure activity and sepsis. A nurse's note dated 03/13/24 read that Resident #67 was transferred to a local hospital after he was observed having seizure like activity, staring, drooling, and with confusion. The nurse's note further revealed the following abnormal vital signs; blood pressure 92/55, heart rate 122, and a temperature of 102.7. The resident was admitted to the hospital 3/13/24 for a urinary tract infection and seizure activity. An interview was conducted with the Social Services Director (SSD) on 9/19/24 at approximately 11:30 AM. The SSD provided me with documentation that the Ombudsman was notified of Resident #67's 6/13/24 discharge and stated that she was giving me all that was available. The documents she provided did not include information that the Ombudsman was notified of Resident #67's discharges to the hospital on 11/8/23 and 3/13/24. On 9/19/24 at approximately 4:30 PM, a final interview was conducted with the Administrator and three Corporate Consultants. The administrative team was informed of the missing Ombudsman notifications for Resident #67's discharges and an opportunity was offered to the facility's staff to present additional information. The Regional [NAME] President of Operations stated the SSD had provided all the information they had available to them.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on observation, Resident interview, clinical record review and staff interview, the facility staff failed to ensure a Pre-admission Screening and Resident Review (PASARR) was completed prior to admission for 3 Residents(Residents #92, #104, & #84) in a sample of 42 residents. The Findings included: 1. Resident #92 was admitted on [DATE] with diagnoses including: Major depressive disorder with psychotic symptoms, anxiety disorder, and avoidant restrictive food intake disorder. Physicians orders for medications were reviewed and revealed several psychotropic medications actively being administered for agitation, frustration, yelling and ongoing behavior monitoring. Those medications are listed as follows; Trazadone/Desyrel - for depression Mirtazipine/Remeron - for clinical depression Buspar/buspirone - for depression Duloxetine/cymbalta - for major depressive/anxiety disorder It is notable to mention that Trazodone, Duloxetine, and Buspar are not recommended to be administered together as combined they may cause Serotonin Syndrome which can be life threatening and may show early symptoms of anxiety, restlessness, disorientation, and delirium according to the National Institutes of Health (NIH). On 9-17-24, an observation was conducted of Resident #92. The Resident was moving quickly around his room and refused to respond to the surveyor who had entered the room and addressed him in a greeting while attempting conversation and interview. The Resident was talking to himself with questions and answers to an apparent inner monolog with himself. On 9-18-24 a review of Resident #92's clinical record was conducted. No previous to admission PASARR (preadmission screening & resident review) for mental illness or intellectual disability was found in the Electronic Health Record (EHR). The only PASARR found was dated 12-13-23, 8 months after admission on 4-5-23. Facility staff were asked to locate any previous PASARR documents, and they stated none had been completed prior to that date. On 9-18-24, an interview was conducted with the Director of Nursing (DON), and the Administrator who stated that this error would be corrected in the future. The Administrator and Director of Nursing were informed of the findings again at the end of day meeting on 9-18-24. The Administrator stated, we will correct this immediately and indicated they would be auditing residents' PASARR's. No further documents were provided. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. For Resident #104, facility staff failed to ensure a Preadmission Screening and Resident Review (PASARR) was completed prior to admission. Resident #104 was admitted on [DATE] with diagnoses including: Depression, and dementia with agitation. Physicians orders for medications were reviewed and revealed psychotropic medications actively being administered for pacing, refusal of care, yelling and ongoing behavior monitoring. Those medications are listed as follows; Citalopram/Celexa - for major depressive disorder. Divalproex/Valproate - for seizures and bipolar disorder. It is notable to mention that using Celexa and Divalproex together can cause seizures, and or hyponatremia (low blood sodium) which can also lead to dehydration when administered together according to the National Institutes of Health (NIH). On 9-17-24, an observation was conducted of Resident #104. The Resident was moving quickly around her room talking to family and her spouse in erratic jerking motions. The Resident was notably frail, under weight, and had poor skin turgor. Her daughter was in the room at the time and an interview was conducted with the family. The Resident was intent on caring for her husband and did not respond to the surveyor who had entered the room and addressed them in a greeting. The Resident appeared confused and responded to her daughter in a word salad response which was indiscernible. On 9-18-24 a review of Resident #104's clinical record was conducted. No previous to admission PASARR (preadmission screening & resident review) for mental illness or intellectual disability was found in the Electronic Health Record (EHR). The only PASARR found was dated 9-17-24, the day survey began. Facility staff were asked to locate any previous PASARR documents, and they stated none had been completed prior to that date. On 9-18-24, an interview was conducted with the Director of Nursing (DON), and the Administrator who stated that this error would be corrected in the future. The Administrator and Director of Nursing were informed of the findings again at the end of day meeting on 9-18-24. The Administrator stated, we will correct this immediately and indicated they would be auditing residents' PASARR's. No further documents were provided. 40026 3. For Resident #84 the facility staff failed to obtain a PASARR (Preadmission Screening and Resident Review) prior to admission on 3/18/24. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #84 was admitted to the facility on [DATE] with diagnoses that included but were not limited to gastrostomy tube, epilepsy, history of venous thrombosis and embolism, dvt/pulmonary embolism, hemiplegia and hemiparesis following a cerebral infarction affecting the left non-dominant side, aphasia (inability to speak) following cerebrovascular disease, and depression. Resident #84's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/21/24 coded the Resident as having a BIMS (Brief Interview of Mental Status) score of 99 - unable to evaluate as Resident is nonverbal. On the afternoon of 9/17/24 during clinical record review it was discovered that Resident #84 did not have a PASARR level 1 completed prior to admission to the facility from the acute care hospital. On 9/18/24 at approximately 1:00 p. m. an interview was conducted with the Social Worker who stated that she has been catching up the ones that have not been done prior to admission. She stated that she was aware that they should be done prior to admission and when they were not done prior, she would do them once they were admitted to the facility. According to the clinical record Resident #84 was admitted to the facility on [DATE] and the PASSAR was completed on the evening of 9/17/24 and uploaded into the clinical record On 9/19/24 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40026 Based on observation, interview, clinical record review and facility documentation the facility staff failed to develop and implement a comprehensive person-centered care plan for one Resident (#84) in a survey sample of 40 Residents. The findings included: For Resident #84 the facility failed to develop a comprehensive care plan that addressed the current contracture to left hand and measures to prevent further contracture. Resident #84 was admitted to the facility on [DATE] with diagnoses that included but were not limited to gastrostomy tube, epilepsy, history of venous thrombosis and embolism, dvt/pulmonary embolism, hemiplegia and hemiparesis following a cerebral infarction affecting the left non-dominant side, aphasia (inability to speak) following cerebrovascular disease, and depression. Resident #84's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/21/24 coded the Resident as having a BIMS (Brief Interview of Mental Status) score of 99 - unable to evaluate as Resident is nonverbal. On 9/17/24 at 1:00 p.m. Resident #84 was observed in bed with her left arm bent at the elbow, the left hand was closed with fingertips pressing down towards the palm. Surveyor asked CNA B if she could gently open Resident #84's hand and it was noted that she had fingernails that were at least 1/4 of an inch over the tip of her fingers. When asked if the Resident's nails should be that long she stated that they should be shorter. When asked why she stated that the Resident's nails could dig into the palm and create a wound. When asked if the Resident had any splints or palm guards that she wore the CNA stated that she was not aware of any devices to protect her hand. On 9/18/24 - an interview was conducted with the PT director who was asked if Resident #84 had been assessed for the use of splints or palm guard to prevent further contractions and protect the palm from potential pressure from fingernails or fingers. The PT (Physical Therapy) Director stated, Resident #84 was assessed on admission and at that time it was decided that due to her inability to verbally express discomfort they decided not to use a splint or palm guard. She is nonverbal and would not be able to tell us if the splint was uncomfortable. The PT Director was asked if they needed an order for applying a rolled washcloth in her palm to prevent further contracting and to absorb sweat and prevent skin becoming macerated and breaking down. The PT Director stated, Using a rolled washcloth is a nursing measure and nursing would have to ask nursing about that. A review of the care plan revealed that Resident #84's care plan did not address the existing contracture, and or the prevention of worsening of the contracture to the left hand. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/18/24 at 2:00 p.m. an interview was conducted with the DON (Director of Nursing) who was asked if she thought Resident #84's fingernails were too long and at risk of pressing into the palm. The DON stated that she thought that the Resident's nails should be cut to avoid the risk of creating a pressure wound. When asked if she thought there should be some intervention to prevent further contracting of her hand, she stated that she thought there should be and she stated she would have the MD refer the Resident to OT (Occupational Therapy) for evaluation for splint or palm guard. When asked if using a rolled washcloth to prevent skin to skin contact, absorb sweat and prevent skin breakdown required an order she stated that it did not. On 9/19/24 during the end of day meeting the Administrator was made aware of the concern and no further information was provided.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40026 Based on observation, interview, clinical record review and facility documentation the facility staff failed to ensure Residents who are unable to carry out activities of daily living receive the necessary services to maintain good grooming, and personal hygiene for three Residents (#'s 5, 38 and 60) in a survey sample of 40 Residents. The findings included: 1. For Resident #5 the facility staff failed to ensure she received adequate assistance for showering bathing and grooming. Resident #5 's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/27/24 coded Resident #5 as having a BIMS (Brief Interview of Mental Status) score of 5/15 indicating severe cognitive impairment. Resident #5 was coded as requiring partial or moderate assistance of 1 staff with bathing, dressing and grooming. Resident #5 had diagnoses that included but were not limited to type 2 Diabetes, COPD (Chronic Obstructive Pulmonary Disease), chronic kidney disease stage 4, hypertension, congestive heart failure, depression, cellulitis of left lower limb, and atrial fibrillation. This Resident uses a walker for mobility. On 9/17/24 at approximately 12:00 p.m. Resident #5 was observed sitting in bed she was dressed in a hospital gown, her hair unkempt and gray facial hair approximately 1 inch long on her chin. Resident #5 was questioned about the facial hair, and she stated that she tries to pull it out, but she can't. When asked if the CNA's shave her on bath days she stated that they did not help her with her bath, she stated that most times she just washes up. A review of the clinical record revealed that the POC (Point of Care - CNA documentation record) coded Resident #5 as, 06 - Independent Resident performs activity without assistance. The following is a review of the excerpt from Resident #5's Care Plan: Assistance required with ADL's may fluctuate based on time-of-day, mood, pain, or fatigue. Date Initiated: 08/27/2024 Place call light within reach. Remind resident to call for assistance if cognitively intact Date Initiated: 05/23/2024 Check resident for incontinence. Wash, rinse and dry perineum. Change clothing PRN after incontinence episodes. Date Initiated: 05/30/24. Resident uses disposable briefs. Change as needed. Date Initiated: 05/30/2024 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/17/24 at approximately 2:00 p.m. an interview was conducted with CNA B who stated that Resident #5 needed help with most things including bathing. When asked if she should be left to do her own shower or bath, she stated that it would not be safe to do so and even if it was safe she wouldn't be able to complete the task properly due to her cognitive status and use of walker. When asked if facial hair should be removed during bath or shower days, she stated that it should. On 9/19/24 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided. 2. For Resident #38 the facility staff failed to ensure adequate bathing and grooming to prevent hair from appearing greasy and unkempt. Resident #38 was admitted to the facility on [DATE] with diagnoses of but not limited to schizophrenia, major depressive disorder, anxiety disorder, insomnia, scoliosis, anxiety disorder and hypothyroidism. Resident #38 uses a manual wheelchair for mobility. Resident #5's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/30/24 coded the Resident as having a BIMS (Brief Interview of Mental Status) score of 0/15. Section C question C0100 is marked as No - Rarely or never understood. The MDS coded the Resident as requiring 2-person assistance with transfers and is dependent on staff for all aspects of ADL (Activities of Daily Living) care with the exception of eating. On 9/17/24 at approximately 12:30 p.m. Resident #38 was observed in her wheelchair dressed in appropriate clothing, her hair appeared greasy and unkempt. Attempts to interview Resident #38 unsuccessful as she was unable verbalize intelligible responses. A review of the CNA (Certified Nursing Assistant) POC Report (Point of Care, electronic documentation to enter care provided to Residents), revealed that Resident #38 received the following care with regards to bathing from September 1st through 19th 2024. 9/3/24 -BB [Bed Bath] 2:59 p.m. 9/11/24 -BB [Bed Bath] 5:13 p.m. 9/13/24 - BB [Bed Bath] 6:44 pm. A review of Resident #38's care plan revealed that she is care planned for dependance on staff for all aspects of ADL care and the care plan did not mention behaviors such as refusal of showers. A review of the facility policy for Nail and Hair Hygiene revealed the following excerpt. Procedure: b. Hair shampooing and trimming (if needed) will be completed on an as needed basis but no less than weekly. c. Daily combing / brushing of hair will be completed with styling as available. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/18/24 at 10:30 a.m. an interview was conducted with CNA C who was asked how often Residents are bathed and she stated that CNA's shower Residents 2x a week or more if needed. When asked if they wash the Residents hair when they shower them, and she stated that they do at least one time a week. On 9/19/24 during the end of day meeting the Administrator was made aware of the findings and no further information was provided. 3. For Resident # 60 the facility staff failed to ensure routine nail care to include cleaning and trimming nails was performed for dependent Residents. Resident #60 was admitted to the facility on [DATE] with diagnoses that included but were not limited to hemiplegia / hemiparesis following cerebral infarction, diabetes type 2, dementia with agitation, aphasia following cerebral infarct, tricuspid valve disorder, and major depressive disorder. Resident #60's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/3/24 coded Resident #60 as having a BIMS (Brief Interview of Mental Status) score of 10/15 indicating moderate cognitive impairment and was coded as requiring supervision and or assistance with all aspects of ADL care. On 09/17/24 12:51 PM Resident # 60 was observed in bed with long fingernails crusted with debris under all of the nails. When asked if she would like her nails trimmed and said she would. When asked if they trim her nails on bath days, she stated they did not remember. A review of the CNA (Certified Nursing Assistant) POC Report (Point of Care, electronic documentation to enter care provided to Residents), revealed that Resident #38 received the following care with regards to bathing from September 1st through 19th 2024. 9/2/24 - S [Shower] 7:02 p.m. 9/5/24 - BB [Bed Bath] 6:37 p.m. 9/9/24 - BB [Bed Bath] 7:52 p.m. 9/12/24 - BB [Bed Bath] 6:20 p.m. 9/16/24 - S [Shower] 7:09 p.m. A review of the facility policy for Nail and Hair Hygiene revealed the following excerpt. Procedure: I Routine Nail Hygiene a. Residents will have routine nail hygiene and hair hygiene as part of the bath or shower. i. Nails should be trimmed immediately after bathing or alternatively, soaking nails in warm soapy water prior to trimming or filing to reduce tearing and provide ease of trimming and filing. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/19/24 during the end of day meeting the Administrator was made aware of the findings and no further information was provided.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40026 Based on observation, interview, clinical record review, and facility documentation, the facility staff failed to ensure Residents receive appropriate services, equipment, and assistance to maintain or improve mobility, for 1 Resident (#84) in a survey sample to 40 Residents. The findings included: For Resident # 84 the facility staff failed to address the contracture of left hand, failed to implement any measures to reduce consequences of contracture and reduce likelihood of worsening of contracture. Resident #84 was admitted to the facility on [DATE] with diagnoses that included but were not limited to gastrostomy tube, epilepsy, history of venous thrombosis and embolism, dvt/pulmonary embolism, hemiplegia and hemiparesis following a cerebral infarction affecting the left non-dominant side, aphasia (inability to speak) following cerebrovascular disease, and depression. Resident #84's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/21/24 coded the Resident as having a BIMS (Brief Interview of Mental Status) score of 99 - unable to evaluate as Resident is nonverbal. On 9/17/24 at 1:00 p.m. Resident #84 was observed in bed with her left arm bent at the elbow, the left hand was closed with fingertips pressing down towards the palm. Surveyor asked CNA B if she could gently open Resident #84's hand and it was noted that she had fingernails that were at least 1/4 of an inch over the tip of her fingers. When asked if the Resident's nails should be that long she stated that they should be shorter. When asked why she stated that the Resident's nails could dig into the palm and create a wound. When asked if the Resident had any splints or palm guards that she wore the CNA stated that she was not aware of any devices to protect her hand. On 9/18/24 at 10:58 a.m. an interview was conducted with the PT director who was asked if Resident #84 had been assessed for the use of splints or palm guard to prevent further contractions and protect the palm from potential pressure from fingernails or fingers. The PT Director stated, Resident #84 was assessed on admission and at that time it was decided that due to her inability to verbally express discomfort they decided not to use a splint or palm guard. She is nonverbal and would not be able to tell us if the splint was uncomfortable. The PT Director was asked if they needed an order for applying a rolled washcloth in her palm to prevent further contracting and to absorb sweat and prevent skin becoming macerated and breakdown. The PT Director stated, Using a rolled washcloth is a nursing measure and nursing would have to ask nursing about that. On 9/18/24 at 2:00 p.m. an interview was conducted with the DON (Director of Nursing) who was asked if she thought Resident #84's fingernails were too long and at risk of pressing into the palm. The DON stated that she thought that the Resident's nails should be cut to avoid the risk of creating a pressure wound. When asked if she thought there should be some intervention to prevent further contracting of her hand, she stated that she thought there should be and she stated she would have the MD refer the Resident to OT (Occupational Therapy) for evaluation for splint or palm guard. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/19/24 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34306 Based on observations, resident interviews, staff interviews, and review of the clinical record, the facility staff failed to provide appropriate care and services to manage indwelling catheters for 2 of 42 residents (Resident #67 and 81), in the survey sample. The findings included: 1. The facility staff failed to ensure that Resident # 67's indwelling catheter was anchored to prevent dislodgement and or trauma. Resident #67 was originally admitted to the facility 2/4/2022 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included quadriplegia, stage 4 pressure ulcers of the left groin and right gluteal fold and an obstructive uropathy. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/6/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #67's cognitive abilities for daily decision making were intact. The resident's active Physician Order Summary (POS) included the following orders dated 7/4/24. Foley catheter 18 french with a 10 milliliters balloon to continuous drainage for a diagnosis of obstructive uropathy. Provide a privacy bag and secure the indwelling catheter's tubing using an anchoring device to prevent movement and urethral traction. The resident's person-centered care plan revised on 1/25/24 read (resident's name) has a #18 indwelling catheter related to a diagnosis of obstructive uropathy. The goal read (resident's name) will be/remain free from catheter-related trauma through review date, 11/04/2024. The interventions included, ensure the stat lock is in place to anchor the Foley tubing. Foley catheter -18 french with a 10 milliliters balloon. Position catheter bag and tubing below the level of the bladder and provide privacy bag. Secure catheter to the leg with security device. On 9/18/24 at 11:26 AM an observation was made of wound care for Resident #67 with the Assistant Director of Nursing (ADON) and Licensed Practical Nurse (LPN) #E. The resident's indwelling catheter was observed dangling enough to cause penile trauma for it was not anchored. Neither nurse appeared to recognize the catheter tubing was not anchored and secured the catheter prior to leaving the resident. On 9/19/24 at approximately 10:45 AM another observation was made of Resident #81's catheter tubing with the ADON and LPN #E. Both nurses stated after viewing the resident's indwelling catheter that it was unsecured. The ADON stated she was not aware of the resident ever declining to have the catheter tubing anchored. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with Resident #67 on 9/19/24 at 11:29 AM. Resident #67 stated he was unaware that the catheter tubing was not anchored and that he had not declined to allow staff to anchor the catheter tubing. 2. The facility staff failed to schedule and ensure that Resident #81 was transported to a follow-up urology appointment regarding his indwelling catheter. Resident #81 was originally admitted to the facility 04/15/22 and readmitted to the facility from an acute care hospital stay on 11/2/23. The current diagnoses included and obstructive uropathy. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/19/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #81's cognitive abilities for daily decision making were intact. In section H (Appliances) the resident was coded as requiring use of an indwelling catheter. The resident's active Physician Order Summary (POS) included the following orders dated 6/2/24. Foley catheter - 18 french with a 10 milliliters balloon to continuous drain for a diagnosis of obstructive uropathy. Provide a privacy bag. The current care plan dated 6/23/24 had a problem which read (name of the resident) has an indwelling catheter related to obstructive uropathy. The goal read the resident will show no signs or symptoms of a urinary tract infection through the next review, 12/18/24. The interventions included the resident has a 18 French Foley. Position catheter bag and tubing below the level of the bladder and provide privacy bag. Secure catheter to the leg with security device. On 9/17/24 during the initial tour at approximately 3:05 PM, Resident #81 was observed sitting on the side of his bed with an indwelling catheter attached. The resident stated that he had a urologist appointment on 6/24/24 for follow-up after a surgical procedure, but because of scheduling and transportation problems he had not been seen by the surgeon. The resident stated the first time the urology appointment was scheduled the transportation company dropped him off at the hospital which required him to attempt to get to the physician's office alone, although the office was on the grounds with the hospital. The resident further stated before he reached the urologist office the transportation company picked him up and transported him back to the facility. The resident stated eight more appointments were scheduled with the urologist and he had yet to be seen by the urologist. An interview was conducted with the scheduling coordinator on 9/19/24 at approximately 1:10 PM. The scheduling Coordinator stated she just scheduled the rides, she does not keep details of the appointments but the nurses do. An interview was also conducted with the ADON on 9/19/24 at approximately 2:00 PM. The ADON stated that Resident #81 did not miss eight appointments but staff did drop the ball regarding Resident #81's urology appointment, which was originally scheduled for 6/24/24. The ADON stated she contacted the urologist office on 9/19/24, scheduled an appointment for 10/3/24 at 2:30 PM and confirmed that she would ensure that the Resident was transported and seen for the newly scheduled visit. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Battlefield Park Healthcare Center	250 Flank Road Petersburg, VA 23805

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/19/24 at approximately 4:30 PM, a final interview was conducted with the Administrator and three Corporate Consultants. The administrative team was informed of the above findings. The Regional [NAME] President of Operations stated they were aware and plans Resident #67's catheter had been secured and another appointment had been scheduled for Resident #81 to be seen by the urologist.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40026 Based on observation, interview, clinical record review and facility documentation the facility staff failed to ensure that Residents who are fed by enteral feeding received appropriate treatment and services and to prevent complications of enteral feeding for 2 Residents (#'s 12 & 84) in a survey sample of 40 Residents. The findings included: 1. For Resident #12 the facility staff failed to ensure 60 ml (milliliter) syringe used for peg tube maintenance were clean and changed daily, failed to ensure that tube feeding was correctly labeled and dated On 9/17/24 at 11:46 a.m. observation was made of Resident #12 in bed dressed in a hospital gown, she had empty bottle of tube feeding hanging undated, and an undated used 60 ml syringe hanging in the plastic wrap from the IV pole. The syringe had thick curdled tube feeding in the base of it, the pump was turned to the off position and the water flush bag was half empty but also undated. The tubing for the tube feeding had no date or time. A review of the clinical record reveled the following enteral feeding order: Enteral Feed Order every shift every shift Jevity 1.5 @ 80 ml/hr. x 12 hours OVERNIGHT (up 8PM, down at 8AM) and water bolus as ordered -Start Date- 06/23/2023 On 9/17/24 at approximately 2:00 p.m. an interview was conducted with LPN B who stated that it is facility policy to change the tube feeding set up (tubing and syringe) daily and to put date and time on them as well as the tube feeding formula being hung. When asked if the tubing and empty tube feeding should be removed when it was completed, she stated that it should. She also stated that physicians usually put the time to hang and time to take down in the order along with the amount of tube feeding and flush to be administered. On 9/18/24 a review of the tube feeding policy read: Page 3 Paragraph 2 g. Change (closed system) administration sets daily. j. Change Syringes tubing, or bottles used for the tube feeding daily label and date items Page 4 d. Label the administration set with date and time of administration including licensed nurse initials. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/19/24 during the end of day meeting the Administrator was made aware of the concern and no further information was provided 2. For Resident #84 the facility staff failed to ensure 60 ml (milliliter) syringe used for peg tube maintenance were clean and changed daily, failed to ensure that tube feeding was correctly labeled and dated. Resident #84 was admitted to the facility on [DATE] with diagnoses that included but were not limited to gastrostomy tube, epilepsy, history of venous thrombosis and embolism, dvt/pulmonary embolism, hemiplegia and hemiparesis following a cerebral infarction affecting the left non-dominant side, aphasia (inability to speak) following cerebrovascular disease, and depression. Resident #84's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/21/24 coded the Resident as having a BIMS (Brief Interview of Mental Status) score of 99 - unable to evaluate as Resident is nonverbal. On 9/17/24 at 12:10 p.m. Resident #84 was observed in bed with tube feeding pump turned off, tube feeding still connected to Residents peg tube, the tube feeding bottle was dated 9/18/24 at 12:00 p.m. (incorrect date and time). The syringe was dated 9/15/24 and had dried tube feeding in the base of the syringe. The tubing for the tube feeding had no date or time. The water flush bag was empty and also undated. A review of the clinical record revealed the following order for enteral feeding: Enteral Feed Order every shift Jevity 1.5 at 55ml/hr. x 20 hours via pump; up at 12pm, down when a total volume of 1100ml infuses (8am) to provide 1650 kcals -Start Date- 03/28/2024. On 9/17/24 at approximately 2:00 p.m. an interview was conducted with LPN B who stated that it is facility policy to change the tube feeding set up (tubing and syringe) daily and to put date and time on them as well as the tube feeding formula being hung. When asked if the tubing and empty tube feeding should be removed when it was completed, she stated that it should. She also stated that physicians usually put the time to hang and time to take down in the order along with the amount of tube feeding and flush to be administered. On 9/18/24 a review of the tube feeding policy read: Page 3 Paragraph 2 g. Change (closed system) administration sets daily. j. Change Syringes tubing, or bottles used for the tube feeding daily label and date items Page 4 d. Label the administration set with date and time of administration including licensed nurse initials. On 9/19/24 during the end of day meeting the Administrator was made aware of the concern and no further information was provided

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 40026 Based on observation, interview, clinical record review, and facility documentation the facility staff failed to ensure that a Resident who needs respiratory care is provided such care, consistent with professional standards of practice, for 1 Resident (#40) in a survey sample of 40 Residents. The findings included: For Resident #40 the facility staff failed to ensure that oxygen tubing was dated when first applied and that the Resident had an order for PRN use of oxygen. On 9/17/24 at approximately 11:45 a.m. Resident #40 was observed in bed dressed in a hospital gown, she was not using oxygen at this time. An oxygen concentrator was by her bedside, the tubing was connected to the concentrator and the end of the tubing with the nasal cannula was on the floor by the bed. The oxygen tubing was not in a plastic bag, and it was not dated. When Resident #40 was asked if she uses oxygen, she stated that she used it only when she became short of breath, and sometimes at night. On 9/17/24 at 12:15 p.m. the oxygen concentrator was again observed with the tubing laying on the floor undated and not in bag. There was no Oxygen in Use sign on the door. A review of the clinical record revealed that Resident #40 had an order for oxygen that read: 9/4/24 - Oxygen 2L/min via nasal cannula for chest pain. On 9/17/24 at approximately 1:30 p.m. an interview was conducted with LPN (Licensed Practical Nurse) B, who stated that Resident #40 did not use oxygen all the time just if she is short of breath. When asked if she had a PRN order, she stated that she did not, but it was a nursing measure. When asked if the tubing should be dated when it is changed, she stated that it should. On the morning of 9/18/24 a review of the clinical record revealed that on 9/17/24 4:37 p.m. the order for oxygen was discontinued Excerpts of the policy and procedure for oxygen use read as follows: Supplemental oxygen may be administered to residents via various routes including the use of a nasal cannula at the order of a physician or provider. Procedure: Initial oxygen set up and use: a. Place an Oxygen in use sign at or on the door. b. Nurse or RT [Respiratory Therapist] will verify the oxygen order for route and LPN [Liters per minute] delivery rate. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	x. Provide Resident with zip lock style baggie to store nasal cannula when not in use. Maintenance: a. Nasal cannula and tubing will be labeled and dated when opened. b. Nasal cannula and tubing are changed weekly or when soiled and labeled with date opened c. Nasal cannula will be changed when contaminated i. Falls on floor ii. Left unused on solid horizontal surface and not in plastic or other type of container. On 9/19/24 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 34306 Based on observations, resident interview, staff interviews, and clinical record review, the facility staff failed to coordinate mental health services for a resident with a diagnosis of depression, who was voicing feelings of increased depression for 1 of 42 residents (Resident #81), in the survey sample. The findings included: Resident #81 was originally admitted to the facility 04/15/22 and readmitted to the facility from an acute care hospital stay on 11/2/23. The current diagnoses included a depression disorder diagnosed , 10/16/2015. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/19/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #76's cognitive abilities for daily decision making were intact. In section D (Resident Mood Interview) the resident was assessed as feeling tired or having little energy 7 - 11 days, having trouble falling or staying asleep, or sleeping too much 12 -14 days and having little interest or pleasure in doing things 12 -14 days, over the 2 weeks period ending 6/19/24. On 9/17/24 during the initial tour at approximately 3:05 PM, Resident #81 was observed sitting on side of his bed. The resident stated the facility takes all his money except $40.00 each month and after he pays his cellphone bill, he has only $20.00 left to make purchases the remainder of the month. The resident also stated that he had a urologist appointment on 6/24/24 for follow-up after a surgical procedure, but because of scheduling and transportation problems he had not been seen by the surgeon. The resident concluded by stating he had been very depressed for five to six months regarding his circumstances which included residing in the facility, no means of making money, lack of family support, and to top it off the facility did not have mental health services available. The resident's Level 1 Preadmission Screening and Resident Review (PASRR) was completed by the Social Services Director (SSD) on 12/23/23 but it did not capture the admission diagnosis of depression. The current Physician's Order Summary (POS) included an order dated 11/06/2023 for Duloxetine (Cymbalta) HCl Oral Capsule Delayed Release Particles - Give 60 mg by mouth in the morning for Depression and Sertraline (Zoloft) HCl Oral Tablet 50 MG - Give 25 mg by mouth in the morning for Depression started on 6/11/2024. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The chart review included two psychiatric visits: one on 10/13/22 and another on 12/16/22. The 12/16/22 psych progress note had a recommendation to increase the Zoloft from 25 mg every day to 50 mg every day, but the POS did not reflect the change or documentation that the resident did not agree to the increase in the Zoloft. The resident's person-centered care plan read (resident's name) uses anti-depressants for a diagnosis of Depression. The goal read (resident's name) will be without complications of anti-depressant medication side effect, through the target date, 12/18/24. The interventions included, encourage resident to voice feelings, and discuss coping skills and consult with pharmacy/medical provider to consider dosage reduction when clinically appropriate. An interview was conducted with the Social Services Director (SSD) on 9/19/24 at approximately 11:30 AM. The SSD stated she was not aware that Resident #81 was experiencing signs of depression but she would visit and offer him support and services of the new mental health practice which was making visits within the facility. A nurse's note dated 9/19/24 at 12:53 PM read that the resident's mood was assessed and he scored 11 on the PHQ-9. The note additionally stated that the resident had no thoughts of being better off dead or inflicting self harm. On 9/19/24 at approximately 4:30 PM, a final interview was conducted with the Administrator and three Corporate Consultants. The administrative team was informed of the above information and the Administrator stated that the SSD and the Nurse Practitioner were ensuring the resident received immediate care and scheduling mental health services. Duloxetine is used to treat depression and anxiety. Duloxetine belongs to a group of medicines known as selective serotonin and norepinephrine reuptake inhibitors (SSNRIs). These medicines are thought to work by increasing the activity of chemicals called serotonin and norepinephrine in the brain. (https://www.mayoclinic.org/drugs-supplements/duloxetine-oral-route/description/DRG-20067247) Sertraline belongs to a group of medicines known as selective serotonin reuptake inhibitors (SSRIs). It works by increasing the activity of a chemical called serotonin in the brain. Sertraline is used to treat depression, obsessive-compulsive disorder (OCD), panic disorder, premenstrual dysphoric disorder (PMDD), posttraumatic stress disorder (PTSD), and social anxiety disorder (SAD). Sertraline belongs to a group of medicines known as selective serotonin reuptake inhibitors (SSRIs). It works by increasing the activity of a chemical called serotonin in the brain. (https://www.mayoclinic.org/drugs-supplements/sertraline-oral-route/description/drg-20065940)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 40026 Based on interview, clinical record review and facility documentation the facility staff failed to ensure Residents were free from unnecessary medications to include duplicate drug therapy for 1 Resident (#5) in a survey sample of 40 Residents. The findings included: For Resident #5 the facility staff failed to ensure the Resident did not receive duplicate drug therapy of the antihistamines Loratadine (Claritin) and cetirizine (Zyrtec). On 9/18/24 during clinical record review it was noted that Resident #5 had the following orders: Cetirizine Oral Tablet 10 MG Give 1 tablet by mouth in the morning for seasonal allergies -Start Date- 05/24/2024 Loratadine Give 1 tablet by mouth in the morning for seasonal allergies -Start Date- 09/13/2024 [*Please note this Resident was being given both of these medications at the 9:00 a.m. med pass] A review of the orders revealed that one order was entered by the Medical Director and the other was entered by the NP (Nurse Practitioner). These medications are both second generation antihistamines and not usually prescribed together as they both are prescribed daily to treat allergies and have the same mechanism of action, giving them simultaneously constitutes duplicate drug therapy. On 9/19/24 at approximately 3:00 p.m. an interview was conducted with the ADON who was asked if it was common to give both of those antihistamines simultaneously, and she stated that it was not. When asked why she stated that they are both antihistamines in the same drug class. According to the Poison Control Center the following excerpts are from the website regarding antihistamines. Cetirizine should not be used at the same time as any sedating drugs such as benzodiazepines or opioids. Taking these medications together can result in excessive drowsiness. This medication can also interact with other medications such as gabapentin . Antihistamines in this group include cetirizine (Zyrtec(R)), loratadine (Claritin(R)), and fexofenadine (Allegra(R)). In high doses, these antihistamines can still cause drowsiness and rapid heart rate. Do NOT double-up on a dose. Do NOT take a dose sooner than you're supposed to. Do NOT take two different antihistamines at the same time. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**Please note this Resident was also on gabapentin100 mg 3 times per day which has the potential to react with both of the antihistamines. ** On 9/19/24 at approximately 4:00 PM the ADON stated that she notified the NP who then discontinued the Claritin. On 9/19/24 during the end of the day meeting the Administrator was made aware of the findings and no further information was provided.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 40026 Based on interview, clinical record review and facility documentation the facility staff failed to ensure Residents were free of significant medication errors for 1 Resident (# 84) in a survey sample of 40 Residents. The findings included: For Resident #84 the facility staff failed to ensure that Resident # 84's blood pressure was checked prior to administering Midodrine (a vasopressor medication that raises low blood pressure). Resident #84 has a BIMS (Brief Interview of Mental Status) score of 99 -unable to evaluate as Resident is nonverbal. Resident #84 has diagnosis of but not limited to intercranial injury, intraparenchymal hemorrhage, seizures, right hemiplegia, dvt/pulmonary embolism, dysphagia, peg tube and is under hospice care. A review of the clinical record revealed the following order: 6/6/24 -Midodrine HCl Oral Tablet 10 MG -Give 1 tablet via PEG-Tube every 8 hours as needed for hypotension sbp [systolic blood pressure] less than 100, for 14 Days. Hold for sbp.> [above]115 A review of the MAR (Medication Administration Record) revealed that the order was started on 6/6/24 and continued through 9/19/24 when surveyor brought this error to the attention of the ADON. The medication was signed off as administered three times daily. On 9/19/24 during clinical record review it was noted that Resident #84's order for Midodrine was supposed to be stopped after 14 days and was not done. It was also noted that only 3 blood pressures were obtained during the 3 months that the medication has been administered they were as follows: 6/6/2024 7:48 p.m. -111 / 64 6/26/2024 10:58 p.m. -119 / 64 8/27/2024 6:01 p.m.- 96 / 60 On 9/19/24 at approximately 9:00 a.m. an interview was conducted with LPN B who was asked if the Resident should have her blood pressure taken when being given a Vasopressor like Midodrine. She stated that there was not an order for blood pressures to be done prior to administration of medication. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/19/24 the ADON was asked if the blood pressure should be taken with the administration of Midodrine and she stated that it should. When asked why it was important to take the blood pressure prior to administration of the medication she stated that it was important because there were parameters on when to hold it. She stated if the blood pressure was not obtained there would be no way of knowing if the medication should be held or given. When shown the MAR she stated that the nurses should have been taking the blood pressures prior to administration of the medication and it should have been stopped after 14 days. She stated that neither the nurses nor the pharmacy caught the 14-day limit on the order. She stated that she would seek further instructions from the ordering physician. On 9/19/24 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49917 Based on observation, staff interviews, and review of facility documents, the facility staff failed to remove expired Covid 19 tests, an expired medication, and expired wound dressings stored in 2 of 2 medication storage rooms; failed to provide the date medications were opened and stored in 1 of 4 medication administration carts. The findings included: 1. On 9/18/24 at 3:10 PM an observation of the medication storage room on Wing 2 with LPN (D) revealed 11 boxes of BinaxNow Covid19 tests expired on 10/27/23. On 9/19/24 at 11:10 AM an interview was conducted with the Regional Nursing Consultant. The Regional Nursing Consultant stated that the BinaxNow Covid 19 tests are expired, and the facility is not able to use these tests. She also stated that these tests have been disposed of, so they are no longer able to be used. 2. On 9/18/24 at 3:48 PM an observation of the medication storage room on Wing 1 with Registered Nurse (RN) (B) revealed: in the refrigerator, there was 1 opened multi-dose vial of Insulin Lantus 100 units/ml with an open date of 7/12/24. A review of the manufacturer's literature indicated to discard the insulin multi-dose vial 28 days after opening. In the cabinet, there was 10 Collagen Wound Dressings with an expiration date of 11-2023. An interview was conducted with RN (B) on 9/18/24 at 3:55 PM. RN (B) stated that she believes the Insulin Lantus is good for 30 or 45 days after opening the vial but is not sure about this. RN (B) also stated that the 10 Collagen Wound Dressings should not be used due to the expiration date. 3. On 9/18/24 at 4:02 PM an observation of the medication administration cart on Wing 1 with Licensed Practical Nurse (LPN) (C) reveled the following medications were opened and undated: 1 bottle of 81 mg Aspirin, 1 bottle of Vitamin D 10 mcg, and 1 bottle of Osmotic Laxative. An interview was conducted with LPN (C) on 9/18/24 at 4:10 PM. LPN (C) stated that per training/competency, every nurse should put the date of opening on medications. The facility's Storage of Medications policy with an effective date of 09-2018 read: All expired medications will be removed from the active supply and destroyed in accordance with facility policy, regardless of amount remaining. On 9/19/24 at approximately 4:15 p.m., a final interview was conducted with the Administrator, Assistant Administrator, Regional Director of Operations, and Regional Nursing Consultant. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 49455 Based on observation, resident interview, and staff interview, the facility's staff failed to offer and provide snacks at bedtime. The findings included: There were no observations made during this survey from 9/17/24 to 9/19/24 of snacks being offered or provided to residents. During the unit council meeting held in the facility on 9/18/24 at approximately 2:30 PM, the six residents that attended complained that they do not get offered snacks and do not receive snacks on a regular basis. The residents stated that it is random and rare to receive snacks at bedtime. The residents also stated, when they do get snacks, they are full of sugar, such as fig bars and cakes. The residents further stated that they have witnessed the dietary staff bring snacks to the unit occasionally, and the nursing staff left them at the desk. The residents stated this allowed the residents who could get to the desk get a snack but the residents who could not, did not. An interview was conducted with the Dietary Manager (DM) on 9/19/24 at approximately 3:15 PM. The DM stated that he is aware snacks are a problem and is in the process of revamping the snack program where healthy options will be offered. The DM also stated that he will be working with nursing leadership to assure the facility gets back on track with passing snacks to all residents as they should. The DM stated he has provided nursing staff a guide, so they will know what snack residents can have based on their ordered diet. The facility staff was able to provide unit council minutes for 7/16/24 and 9/16/24. The facility staff provided a unit council sign in sheet dated 5/21/24 without any minutes, no meeting was held in June, sign in sheet and minutes were provided for 7/16/24, no meeting was held in August, and sign in sheet and minutes were provided for 9/16/24. On 9/19/24 at approximately 5:00 PM, the above findings were shared with the Executive Director (Administrator), Director of Nursing, Assistant Director of Nursing, Regional Minimum Data Set Coordinator, and Regional Corporate Consultant. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided.

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	495252	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Battlefield Park Healthcare Center	250 Flank Road Petersburg, VA 23805

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 31199 Based on observation, staff Interview and facility documentation review, the facility staff failed to prepare and serve food in a safe and sanitary manner. The findings included: The facility staff failed to ensure the ice machine plumbing had an air gap to prevent the back flow of contaminated water, and failed to maintain a sanitary food storage and preparation area in accordance with professional standards for food service safety. On 9-17-24 at approximately 12:00 PM, the kitchen area of the facility was inspected with the dining services manager, and Regional food Services Director. In the main kitchen food preparation and cooking area a clean silverware tray was found on a rolling cart with a dish sponge on a stick commingled with the clean silverware. the sponge was wrapped in plastic wrap and when opened dead insects resembling small flies fell out, and some were still imbedded in it. On a separate cart covered in a brown liquid sticky substance, was noted bread clips, food crumbs and food debris, commingled with clean glasses which were stacked on the cart for use with the lunch meal being prepared. On a green cart with a segmented tray on top was found forks, knives, and spoons each in a segment for ease of placing on food trays. The cart was wheeled out of the dishwashing room, reportedly clean, and was observed to have approximately a quarter inch of cloudy liquid, and pieces of food debris in each of the segments. In the dry storage area, a cart containing trays full of individual small plastic cups with lids full of mandarin oranges was found which had been taken from a multiple portion large can. The cups had not been refrigerated and were reportedly for use the following day. Another rolling cart was in the dry storage area adjacent to the oranges which was wet on top, and contained a butter knife encrusted with what appeared to be peanut butter, a large carving knife with a brown dried on substance on the blade, brown and tan crumbs and food debris. In the dry storage area on and around the shelving units which held the supplies, clear hard plastic bins were found which contained single use condiment packets such as ketchup, mustard, etc. In the bins with the condiments, were bread bag ties, paper clips which were rusted, crumbs and food debris, and what appeared to be smears of open single use condiments which had spilled into the bin. On one of the shelving units was found a Styrofoam food take out box which contained a dried hamburger which was half eaten and had obviously been there for a substantial period of time as the bread and meat were hard like cardboard. Under all of the shelving units were more cracker crumbs, food debris, mouse feces, and a mouse trap which was so crusted on top that the name of the device was obstructed and could not be read. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The floors were sticky throughout the kitchen and almost pulled the surveyors shoe off. In one area by the back counter a thick greasy substance was encountered on the floor which caused slipping. The large Ice machine for the kitchen and for hydration for the Residents was observed and found to have the drain pipe directly on the floor of the kitchen with mildew and a black mold like substance around the base board and floor in that area. Water damage was clearly noted to the wall behind the pipe, and the pipe end had also become encrusted with the black substance. The Dining Services Manager stated that they would begin to clean the kitchen immediately, and that he had forgotten to ask anyone to take care of the mouse trap, and stated Yes there was a problem with mice I will admit. On 9-17-24 the Regional manager and Dining Services Manager were made aware of the issues, and had no further information to provide. On 9-18-24 the Regional Director stated that a deep cleaning had begun and also stated that the Dining Services Manager had resigned. No further information was provided.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 40026 Based on observation, interview, and facility documentation, the facility staff failed to maintain an effective pest control program so that the facility is free of pests and rodents. The findings included For the facility, the facility staff failed to follow the pest control company recommendations for reducing / eliminating pests from the facility. On 9/17/24 during the initial tour of the kitchen Surveyor C noted mouse droppings in the dry storage area, small flies in a dish washing sponge placed in a tray with Clean silverware 9/17/24 - 9/19/24 - during the 3 days of survey flies and gnats were noted in the conference room by all surveyors, dead bugs were noted in light fixtures throughout the building, and gnats and flies noted throughout the building in various Resident rooms. A review of the pest control book revealed the following excerpts from the service receipts: 4/19/24: Finding: Exit door doesn't close /seal properly 1/4 inch or greater gap exists. Fire door in 100 wing facing sheds is rusted and potentially needs to be replaced. Exit door doesn't close /seal properly 1/4 inch or greater gap exists. Fire door facing auxiliary parking lot is rusted and potentially needs to be replaced. Action Needed: Install / replace door sweeps. Exclusion measures here will reduce the number of pests entering the facility. 5/10/24:Finding: Exit door doesn't close /seal properly 1/4 inch or greater gap exists. Fire door in 100 wing facing sheds is rusted and potentially needs to be replaced. Exit door doesn't close /seal properly 1/4 inch or greater gap exists. Fire door facing auxiliary parking lot is rusted and potentially needs to be replaced. Action Needed: Install / replace door sweeps. Exclusion measures here will reduce the number of pests entering the facility. 6/13/24 Findings -Kitchen - Mice noted during service 1 mouse captured in kitchen additional traps laid and discussed plan of action with Director of Maintenance. Action Needed - Exit door doesn't close /seal properly 1/4 inch or greater gap exists. Fire door in 100 wing facing sheds is rusted and potentially needs to be replaced. Exit door doesn't close /seal properly 1/4 inch or greater gap exists. Fire door facing auxiliary parking lot is rusted and potentially needs to be replaced. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Action Needed: Install / replace door sweeps. Exclusion measures here will reduce the number of pests entering the facility. 7/26/24 - Finding: Floor drains need cleaning. Floor drains throughout kitchen need thorough cleaning. Food debris found. Lots of food build up in kitchen under shelving. Action needed: Please clean in and around drains frequently to help prevent pest breeding sites. Please clean regularly. [under shelving] 8/30/24 Finding: Small flies noted during service fruit flies in kitchen. Drywall over baseboards I kitchen are rotten Excess water noted standing on ground beneath sink in kitchen. Action Needed: Please address structural concern. [drywall] Keep areas dry [under sink] This area was inspected and serviced. On the afternoon of 9/19/24 observations of the kitchen revealed that the drywall over the kitchen baseboards had not been repaired or replaced, the exit doors still had gaps where the door sweeps needed replacing, and the floor drains continued to need cleaning, fruit flies were noted in the kitchen. On 9/19/24 at approximately 2:00 p.m. an interview was conducted with the Maintenance Director who stated that he had fixed the doors, but the wheelchairs keep hitting them and knocking off the door sweeps. When asked if the other repairs and recommendations by the pest control company had been completed, he stated that he was not aware that repairs were needed. On 9/19/24 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.